TODAY'S DATE:

_____/_____/_____

WELCOME
----TO MCKENNA ORTHODONTICS--

The benefits of a happy, healthy smile are immeasurable. Everyone should love to smile. Please fill out this form completely. The better we communicate, the better we can care for you.

TELL US ABOUT YOUR CHILD

Child's Name: _____ ☐ **Male** ☐ **Female**

Child's Date of Birth: _____/_____/_____ **Age** _____

Home Address: _____ **City:** _____ **Zip**: _____

Home Phone #: _____ **Cell Phone #:** _____

Child's email_____

School: _____ **Grade**:_____

Hobbies / Sports: _____

General Dentist: _____ **Date of Last Visit**: _____

Whom may we thank for referring you? _____

INFORMATION BELOW MUST BE FILLED OUT COMPLETELY

MOTHER'S INFORMATION ☐ Step-Mother ☐ Guardian

Name: _____ **Date of Birth**: _____/_____/_____

Home Phone #: _____ **Work Phone #**: _____ Cell Phone #: _____

Mother's Email Address: _____

Employer Name: _____

Social Security #: _____

FATHER'S INFORMATION ☐ Step-Father ☐ Guardian

Name: _____ **Date of Birth**: _____/_____/_____

Home Phone #: _____ **Work Phone #**: _____ **Cell Phone #**: _____

Father's Email Address: _____

Employer Name: _____

Social Security #: _____

If divorced, who is the primary residential parent?_____

PRIMARY ORTHODONTIC INSURANCE

Policy Holder's Name: _____

Date of Birth: _____/_____/_____ **Social Security #** _____

Employer Name: _____

Insurance Company: _____

Insurance Company Address:_____

City: _____ State: _____ Zip: _____

Insurance Company Phone #:_____ **Group / Plan #:** _____

Relationship to Patient:_____

Please notify us if you have a secondary insurance policy that covers Orthodontic treatment.

WHAT ARE THE MAIN CONCERNS THAT YOU WOULD LIKE ORTHODONTICS TO ADDRESS?

Parent: _____

Child: _____

Dentist: _____

Has your child ever been evaluated for or had orthodontic treatment before ☐ Yes ☐ No

Have there been any injuries to the face mouth, teeth or chin? ☐ Yes ☐ No
Please explain: _____

Have adenoids or tonsils been removed? ☐ Yes ☐ No

Has your child been informed of any missing or extra permanent teeth? ☐ Yes ☐ No
Which ones? _____

Has your child ever had any pain / tenderness in his / her jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Does your child brush his / her teeth daily? ☐ Yes ☐ No

Child's Physician: _____

Phone#: (_____) _____

Please describe your child's current physical health:
☐ Good ☐ Fair ☐ Poor

Please list all the drugs that your child is currently taking:

_____

Please list all the drugs that your child is allergic to:

_____

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?

Y	N	Abnormal Bleeding	Y	N	Diabetes
Y	N	Allergies to Drugs	Y	N	Disabilities
Y	N	Allergy to Latex/Metals	Y	N	Hearing Impairment
Y	N	Allergy to Plastic	Y	N	Heart Murmur
Y	N	Any Hospital Stay	Y	N	Hemophilia
Y	N	Any Operations	Y	N	Hepatitis
Y	N	Asthma	Y	N	HIV+ / AIDS
Y	N	Cancer	Y	N	Kidney / Liver Problem
Y	N	Congenital Heart Defect	Y	N	Rheumatic / Scarlett Fever
Y	N	Epilepsy	Y	N	Tuberculosis (TB)

Please discuss any medical problems that your child has had:

_____

_____

_____

_____

_____

DOES / DID YOUR CHILD HAVE ANY OF THE FOLLOWING HABITS?

Y	N	Clenching / Grinding Teeth	Y	N	Nursing Bottle Habits
Y	N	Lip Sucking / Biting	Y	N	Speech Problems
Y	N	Mouth Breather	Y	N	Thumb / Finger Sucking
Y	N	Nail Biting	Y	N	Tongue Thrust

I acknowledge that the above information is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform Dr. McKenna of any changes that occur after this date. I hereby authorize Dr. McKenna and his team to take x-rays and perform a complete orthodontic evaluation/examination. I understand that, where appropriate, credit bureau reports may be obtained.

Signature: _____ **Date:** _____

Treatment Options / Notes: _____

_____

_____

_____

_____